THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-1158.M2

October 07, 2003

CORRECTED DECISION Date of injury in "Clinical History" changed to ____.

Re: Medical Dispute Resolution MDR #: M2-03-1785-01 IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Certified in Chiropractic Medicine.

Clinical History:

The patient sustained a work-related injury on ____ to his lower back. Minimal records were available for review. Prior treatment apparently included surgery and a chronic pain management program; these were the only records available for review.

Disputed Services:

Proposed Work Conditioning Program, 5 X Week for 4 Weeks.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The services in question are medically necessary in this case.

Rationale:

This patient had a laminectomy and facetectomy with fusion from L-4 to the sacrum on 02/21/02. The records fail to demonstrate any rehabilitation exercise program following surgery. Only the chronic pain management program notes were included in this review. The CPMP included counseling, medical relaxation techniques, and medication.

Generally, following surgery of this magnitude, a rehabilitative exercise program should be implemented. Notes reviewed failed to indicate any such program was instituted on this patient. Thus, a rehabilitative exercise program would be considered reasonable and medically necessary.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings Texas Workers' Compensation Commission P.O. Box 40669 Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on October 3, 2003.

Sincerely,